Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

2015 Premium Surcharge Change Form

Use this form to report a change that affects your surcharge for tobacco use and/or spouse or registered domestic partner* coverage.

Whether the change adds or removes a surcharge, it will take effect the month after your employer receives the form (if you're an employee) or the PEBB Program receives the form (all other subscribers). If you submit your form on the first day of a month, the change will be made that month. Changes are effective no earlier than January 1, 2015.

Type or print clearly in black ink.

Section 1: Tobacco use premium surcharge

See details on the *2015 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb**.

A monthly $25-per-account surcharge will be required in addition to your premium if you or a family member on your PEBB medical coverage uses a tobacco product.

The surcharge will not apply if you and all family members ages 18 and older who use tobacco products are enrolled in your PEBB medical plan's tobacco cessation program, or if children ages 17 and younger who use tobacco products access information and resources at **teen.smokefree.gov**.

Tobacco use is defined as any use of tobacco products within the past two months. It does not include the religious or ceremonial use of tobacco.

List yourself and each family member you enroll on your PEBB medical coverage.
Select the "YES" or "NO" checkbox to attest for each family member, regardless of age.
If you check "YES" or leave the check boxes blank for yourself or any family member, you will pay the monthly $25 surcharge.
(To list more family members, attach additional copies of this form.)

	First name	Middle initial	Last name	Last four digits of Social Security number	**Has this person used tobacco products in the last two months?** YES	NO, or this family member has used the tobacco cessation resources noted above.
You (subscriber):					☐	☐
Family member:					☐	☐
Family member:					☐	☐
Family member:					☐	☐
Family member:					☐	☐
Family member:					☐	☐
Family member:					☐	☐
Family member:					☐	☐
Family member:					☐	☐
Family member:					☐	☐
Family member:					☐	☐

*as defined by Washington Administrative Code 182-12-260(2)

(continued)

Section 2:
Spouse or registered domestic partner coverage premium surcharge

Complete this section only if you enroll a spouse or registered domestic partner on your PEBB medical coverage. If you do not have a spouse or registered domestic partner enrolled on your PEBB medical plan, skip this section.

A $50-per-month surcharge will be required in addition to your premium if you have a spouse or registered domestic partner enrolled on your PEBB medical coverage, and your spouse or registered domestic partner has chosen not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic.

See if this surcharge applies to you by reviewing the *2015 Premium Surcharge Help Sheet* and, if directed, complete the *2015 Spousal Plan Calculator.* Find both at **www.hca.wa.gov/pebb** .

If you enroll a spouse or registered domestic partner on your PEBB medical coverage and you check "YES" or leave the check boxes below blank, you will pay the monthly $50 surcharge.

Does the spouse or registered domestic partner coverage surcharge apply to you?

❑ **YES**
I used the *2015 Premium Surcharge Help Sheet* and, if directed, completed the *2015 Spousal Plan Calculator* online.

❑ **NO**
I used the *2015 Premium Surcharge Help Sheet* and, if directed, completed the *2015 Spousal Plan Calculator* online.

Which questions, if any, on the *2015 Premium Surcharge Help Sheet* did you check "NO"? Check all that apply.

❑ Question 1 ❑ Question 2 ❑ Question 3 ❑ Question 4 ❑ Question 5 ❑ Question 6

❑ **Employer or PEBB Program to determine**
I used the *2015 Premium Surcharge Help Sheet* and am completing and submitting a paper *2015 Spousal Plan Calculator* with this form. My employer or the PEBB Program will determine whether my spouse's or registered domestic partner's employer-based group medical insurance is comparable to UMP Classic.

Section 3: Signature

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not provide timely, updated information, I will owe surcharges to the PEBB Program. This form replaces all *Premium Surcharge Attestation Forms, Premium Surcharge Change Forms*, and electronic surcharge attestations previously submitted.

HCA's Privacy Notice: We will keep your information private as allowed by law.
To see our Privacy Notice, go to **www.hca.wa.gov/pebb** .

Name (print) _____ Last four digits of Social Security number _____

Signature _____ Date _____

Agency name (employees only)_____

If you are:	Return it to:
An employee	Your personnel, payroll, or benefits office.
Any other subscriber	PEBB Program, Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684; or fax to: 360-725-0771

Please sign and date this form.

If the *2015 Premium Surcharge Help Sheet* directed you to complete the *2015 Spousal Plan Calculator,* please attach the paper *2015 Spousal Plan Calculator* (if you didn't complete the calculator online).

To obtain this document in another format (such as Braille or audio), call 1-800-200-1004.
TTY users may call through the Washington Relay service by dialing 711.